# BLACK INFANT HEALTH (BIH) PROGRAM

## Background

California started to meet the challenge of improving the health of African-American women, infants, and children in 1989, with the passage of Senate Bill (SB) 165, Budget Act of 1989 (Alquist, Chapter 93, Statutes of 1988). SB 165 appropriated $1.4 million for new, innovative projects to reduce the rate of Black infant mortality in California and for the formation of a leadership Committee. The State Department of Health Services formed the Black Infant Health (BIH) Leadership Committee to provide advice on state-of-the art strategies for reducing African-American morbidity and mortality, as well as suggestions for funding innovative projects. Initial funding was provided to four innovative demonstration projects. Through a subsequent Initiative, additional funding was made available to the 16 health jurisdictions (cities and counties) where over 90 percent of California's African-American live births and infant deaths occur.

The purpose of the BIH Program is to eliminate the disproportionate African-American infant mortality rate and to improve related health status indicators in the African-American communities of California. The BIH Program is designed to identify "at risk" pregnant and parenting African-American women, to provide them assistance that will aid in their accessing and maintaining appropriate health care for themselves and their infant through their first year of life, and to receive other family supportive services (e.g. child care, job training, assistance with food and housing, transportation, etc.).

The BIH Program is currently implemented in 17 health jurisdictions where 93 percent of African-American live births and deaths occur. It is within these areas that present and future efforts to reduce African-American infant mortality are directed with the expectancy of improving outcomes.

The BIH Scope of Work is based upon the following Healthy People 2010 objectives:

- Increase to at least 90 percent, the proportion of all pregnant women who receive continuous prenatal care starting in the first trimester of pregnancy.
- Reduce low birth weight (LBW) babies to no more than 5 percent of all live births.
- Reduce the African-American infant mortality rate to no more than 11 per 1,000 live births.
- Reduce the African-American maternal mortality rate to no more than 5 per 100,000 live births.

An additional BIH objective is the implementation of the prematurity prevention guidelines.

## 1.0 LOCAL BIH ACTIVITIES

1.1 **Policy:** The State Maternal and Child Health (MCH) Branch funds local health jurisdictions to conduct a BIH Program in their communities to improve the birth outcomes and overall health of African-American women and their families.

1.2 **Requirements:**
All agencies will:

1.2.1 Refer their clients to prenatal care. They should seek out culturally competent providers for referral. Cultural competence within the health system requires:

- Care that is administered with an understanding of and respect for the patient's health-related beliefs and cultural values; care that takes into account disease prevalence and treatment outcomes specific to different populations; and that incorporates the active participation of community members and consumers.

- Staff who respect the health-related beliefs, interpersonal styles, and attitudes and behaviors of the individuals, families, and communities they serve.

1.2.2 Operate a program that incorporates the four interventions entitled, "Community Exchange/ Awareness", "Case Management", "Social Support and Empowerment", and "Role of Men Services".

1.2.3 Promote overall health care that includes preconception and prenatal care including proper nutrition.

1.2.4 Coordinate and collaborate with other relevant programs and service providers such as Alcohol and Drug Programs to prevent substance abuse, and promote smoking cessation to improve birth outcomes for African-Americans.

1.2.5 Educate pregnant women to recognize signs and symptoms of pre-term labor, modify behaviors that may promote pre-term labor, and advise women when to seek medical care.

1.2.6 Discuss newborn sleeping patterns with mothers during follow-up visits and educate African-American families and the community on strategies to reduce the risks of Sudden Infant Death Syndrome (SIDS) deaths including the Back-to-Sleep campaign.

1.2.7 Host at least two Celebrate Healthy Baby Events to solicit the community's support, assistance, and volunteerism to enhance access to perinatal care, provide education and information regarding community resources, and other support services.

1.2.8 Implement client follow-up services to adhere to standardized medical guidelines for well-baby care, proper immunizations, and maintenance of other services seen as essential for the well being of infants from birth through 12 months.

1.2.9 Maintain a culturally competent BIH Community Advisory Board for the purpose of developing and strengthening local partnerships and to solicit input and advice on strategies to alter adverse African-American birth outcomes.

1.2.10 Share Fetal Infant Mortality Review (FIMR) findings concerning African-American infant deaths with local BIH Advisory Boards in order to effect change to reduce fetal and infant mortality.

1.2.11 Update and maintain the BIH Data Collection System (MIS).

**1.3 Procedures for Local Activities**

1.3.1 Submit the MCH Annual Report as specified in MCH Report Section1.3.

1.3.2 Submit monthly data pursuant to the Subcontractor UCSD.

## 2.0 Key Personnel

**2.1 Policy:** Each BIH Program must have a BIH Coordinator that is approved by the State MCH Branch and works in conjunction with the MCH Director. The MCH Branch must approve any changes to the position including allotted time, duties, job specifications, and organization charts.

**2.2 BIH Coordinator Requirements**

2.2.1 Implement and maintain a culturally competent BIH Program including recruiting, training, and retaining staff that reflect and respond to the values and demographics of the communities served.

2.2.2 Must assume responsibility to develop, maintain, and operate the BIH Program as specified in 1.0 Local BIH Activities.

2.2.3 In collaboration with MCH conduct a local Community Needs Assessment every five years as required by Title V. The BIH component of the MCH Community Needs Assessment should be specific to the African-American community and aimed at facilitating improved perinatal services for pregnant and parenting African-American women, infants, and their families.

2.2.4 Identify by zip codes/census track areas of pregnant and parenting African American women to assure the provision of program services in zip code areas with the highest concentration of African-American births and deaths.

2.2.5 Facilitate the formation and maintenance of a culturally competent BIH Advisory Board.

2.2.6 Set the goal for the number of clients to be served.

2.2.7 The priorities for serving clients in the BIH program is:

- Serve 25-30% of all African-American births.
- Half of the pregnant women served should be first time pregnant moms.
- Provide follow up services, for up to 12 months, to mothers and infants.

2.2.8 Identify local objective(s) to be implemented in addition to program interventions. The local objective(s) should be based upon the Needs Assessment or findings from the FIMR Review or the BIH Advisory Board.

2.2.9 Coordinate at a minimum two BIH “Celebrate Healthy Baby” events annually.

2.2.10 Serve on the Fetal Infant Mortality Review (FIMR) Committee to share FIMR findings with the BIH Advisory Board and to further community analysis and community-based resolutions.

2.2.11 Attend and participate in semi-annual statewide meetings as scheduled and coordinated by the MCH Branch. At a

minimum, each program is required to send at least one representative to scheduled BIH meetings.

### 2.3 Procedures for Key Personnel

2.3.1 Please refer to Procedures for Key Personnel of the MCH policies and procedures.

3.0 **Policy:** All BIH programs must have patient education and community awareness activities.

3.1 **Requirements:**

3.1.1 Target pregnant and parenting African-American women and follow the community exchange/awareness intervention curriculum as made available by the MCH Branch.

3.1.2 Track clients to assure timely acquisition of appropriate and necessary well-baby care, proper immunizations, and maintenance of other services seen as essential and necessary for the well being of infants and children from birth through 12 months. Client tracking includes case management, patient education, care coordination, and/or other non-medical indicators, such as adequacy of available housing and employment opportunities.

3.1.3 Establish coordination, referral, and follow-up procedures for program clients who have experienced or who may be at risk for family, community, and/or relationship violence.

3.1.4 Develop and maintain promotional materials which may include items such as brochures, fact sheets, canvas bags, well baby kits, baby books, baby blankets, pens, public service announcements, videos, apparel, newsletters, etc.

### 3.2 Procedures for Patient Education and Community Awareness Activities

3.2.1 Submit all promotional materials developed by the agency to MCH Branch for approval prior to its use.